IN THE COURT OF APPEALS OF TENNESSEE
AT NASHVILLE
October 6, 2003 Session

ROY MCPHERSON v. FORTIS INSURANCE COMPANY, ET AL.

Appeal from the Circuit Court for Davidson County
No. 01-1228 Barbara N. Haynes, Judge

No. M2003-00485-COA-R3-CV - Filed January 12, 2004

An application for a policy of health insurance was filled out by a secretary in the office of the agent for the insurance company following a conversation by telephone with the plaintiff who later signed the application without reading it. Four of the questions were concerned with the plaintiff's health history, all of which were answered 'No', which were incorrect. The company rescinded the policy because of the misrepresentations. In the meantime, the plaintiff developed back problems, underwent surgery, and incurred considerable medical expenses. He filed this action, insisting that he answered all questions truthfully, but that the secretary noted his answers differently. Summary judgment was granted on motion of the defendant. We affirm.

Tenn. R. App. P. 3 Appeal as of Right; Judgment of the Circuit Court is Affirmed

WILLIAM H. INMAN, SR. J., delivered the opinion of the court, in which WILLIAM C. KOCH, JR., and WILLIAM B. CAIN, JJ., joined.

Michael M. Castellarin, Nashville, Tennessee, attorney for appellant, Roy McPherson.

Louis Marshall Albritton and Laura C. Elliott, Nashville, Tennessee, attorneys for appellee, Fortis Insurance Company.

Winston N. Harless, attorney for appellee, John Rutledge, Jr.

OPINION

I.

Tennessee Code Annotated § 56-7-103 provides:

> . . . no written or oral misrepresentation or warranty therein made in the negotiations of a contract or policy of insurance, or an application therefore, by the insured on the insured's behalf, shall be deemed

> material or defeat or void the policy or prevent its attaching, unless such misrepresentation of warranty is made with actual intent to deceive, or unless the matter represented increases the risk of loss.

To avoid coverage under this statute the insurer must prove that (1) the answers in the application for the policy were false, (2) the false answers were given with the intent to deceive the insurer, or (3) that the false answers materially increased the risk of loss. ***Womack v. Blue Cross & Blue Shield***, 593 S.W.2d 294 (Tenn. 1980), ***Spellmeyer v. Tennessee Farmers Mut. Ins. Co.***, 879 S.W.2d 843 (Tenn. Ct. App. 1993).

In the case at Bar, the plaintiff submitted an application for a policy of health insurance to Fortis Insurance Company through the Rutledge insurance agency. He signed the application in Rutledge's office in the presence of Sandra League, who accompanied him, and Rutledge's employee, Debbie Alexander.

Before going to Rutledge's office to sign the application, the plaintiff, and his secretary, Ms. League, talked to Ms. Alexander by telephone. She testified that all of the health information about Mr. McPherson was obtained from Ms. League, although Mr. McPherson said that he answered a few of Ms. Alexander's questions, principally about a past prostate condition. The plaintiff testified that he believed Ms. Alexander was skimming over and highlighting the questions but that he did not know whether he was asked every question on the application or not but in any event he said nothing about it.

The plaintiff signed the application without reading it. He was under no compunction, was a good reader, and asked no questions.[1] As pertinent here, the application (sometimes referred to as the enrollment form) contained four (4) questions:

> Within the last 10 years has any proposed insured: Had any diagnosis of, received treatment for, or consulted with a physician concerning: e) mental disease or nervous disorder including but not limited to any emotional disorder, anxiety, depression, attention deficit disorder, eating disorder, or psychiatric treatment or counseling?

The answer marked on the Enrollment Form was "No."

> Within the last 10 years has any proposed insured: Had any diagnosis of, received treatment for, or consulted with a physician concerning: (g) the genitourinary system including but not limited to any kidney disorder, kidney stones, cystitis, prostatitis, bladder infections, or sexually transmitted disease?

[1] He had recently retired from the automobile business. Ms. League had been his secretary for seventeen years. He dealt with contracts almost on a daily basis.

The answer marked on the Enrollment Form was "No."

> Within the last 10 years has any proposed insured: Had any diagnosis of, received treatment for, or consulted with a physician concerning:
>
> (k) Cancer? Provide location, type of cancer and treatment received:
> (l) Tumor, cyst, growth of any kind; any breast or skin disorder? Provide location, state if treated or removed and date."

The answers marked on the Enrollment Form to both of these questions was "No."

> Is any proposed insured currently taking or taken within the past 3 months any medication or receiving medical treatment of any kind: Provide details of treatment including name and dosage of all medications.

The answer marked on the Enrollment Form was "No."

The Enrollment Form, at the top of the page signed by the plaintiff provided, in bold print, that

> I represent to the best of my knowledge and belief that all statements and answers on this enrollment form are complete and true. The enrollment form and any amendments shall be the basis for the contract.

It further provides immediately above the McPherson's signature, that:

> We, the undersigned Proposed Insured(s) and agent acknowledge that the Proposed Insured(s) has read the completed enrollment form. We understand and acknowledge that any fraudulent statement or material misrepresentation on the enrollment form and/or any amendments may result in claim denial or contract rescission, subject to the time limit on certain defenses or incontestability provisions of the contract.

Fortis issued a policy to the plaintiff effective August 15, 2000. The plaintiff was experiencing back pain[2] and corrective surgery was recommended. On December 5, 2000 a form letter generated by Fortis notified the plaintiff and his surgeon and hospital that the proposed surgery scheduled for December 14, 2000 was medically necessary.

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[2] The plaintiff alleged in his complaint that he first sought medical treatment for his back pain on July 25, 2000, or twenty-one days *before* the policy was issued.

In the meantime, on December 7, 2000, Fortis determined to rescind the policy because of misrepresentations in the application, and a letter to that effect was posted to the plaintiff on December 13, 2000. He did not see the letter until his release from the hospital.

The rescission of the policy was based on the plaintiff's unrevealed medical history which included a diagnosis of and treatment for prostatitis, melanoma, and depression which required hospitalization.

II.

Upon receipt of the letter of rescission, Mr. McPherson filed this action to recover benefits under the policy. He alleged that any incorrect information in the application was attributable to the agent-employee of Rutledge, the agent for Fortis Insurance Company, which is estopped to deny coverage under the policy. He further alleged that Rutledge and his employee were negligent in the manner in which the application was executed and that he was induced to cancel existing health insurance and proceed with elective back surgery, and that Fortis had no right to rescind the policy. He demanded monetary damages "pursuant to the Tennessee Consumer Protection Act for the defendants' intentional or negligent deceptive acts, but with no antecedent allegations."

III.

Fortis Insurance Company and Rutledge filed separate answers. Rutledge alleged that he was a "producer" for Fortis, that he had no authority to bind coverage or issue policies, and that his authority was limited to the submission of applications to Fortes. He alleged that Debbie Alexander, his employee, assisted the plaintiff in filling out the application and that she faithfully recorded the answers to the questions.

Fortis denied the inducing portions of the complaint, and alleged that it rescinded the policy after it discovered that the plaintiff had made material, false representations about his health history. It further alleged that the medical treatment rendered to the plaintiff was for a pre-existing condition and thus was not covered by the policy.

IV.

Fortis Insurance Company filed a motion for summary judgment, alleging that there were no genuine issues of material fact, and that the plaintiff made material misrepresentations concerning his health history in the application for coverage; specifically, that he failed to disclose that he suffered from depression, prostatitis and melanoma, which increased the risk of loss and voided the policy as a matter of law. The defendant Fortis further alleged that is was undisputed that the plaintiff's back problems were a pre-existing condition for which policy benefits were not payable.

In support of the motion, Fortis filed the application signed by the plaintiff, its Underwriting Refund memo, the policy, the letter of rescission, the affidavit of Robin R. Riccioli, the deposition of the plaintiff, a Statement of Material Undisputed Facts, and a Memorandum of Law.

V.

Rutledge also filed a motion for summary judgment, alleging the absence of any disputed material facts and that he was entitled to judgment as a matter of law because the gross negligence of the plaintiff barred any claim against him. He relied upon a Memorandum of Law, Statement of Material Facts, the depositions of the plaintiff, Sandra League, Debbie Alexander, and certain of the plaintiffs' responses to Requests for Admissions.

VI.

The motions were consolidated for hearing and each was granted upon a finding that there were no genuine issues of material fact and that the defendants were entitled to judgment as a matter of law. The plaintiff appeals and presents for review a litany of prolix issues which we restate. As to Fortis Insurance Company, whether the misrepresentation made by the plaintiff entitled Fortis to rescind the policy, but even so, whether the plaintiff's back condition was pre-existent and therefore not covered by the policy; and, as to Rutledge, whether the plaintiff breached his duty to read his application for insurance before signing it in order to verify the accuracy of the information therein stated.

VII.

Summary judgment is not a disfavored procedural device and can be used to conclude any civil case, including negligence cases that can be, and should be, resolved on legal issues alone. ***Mansfield v. Colonial Freight Sys.***, 862 S.W.2d 527 (Tenn. Ct. App. 1993). The standard of review on motions for summary judgment is well settled in Tennessee. A moving party is entitled to summary judgment when it establishes from the pleadings, depositions, answers to interrogatories and admissions on file, together with affidavits, if any, that no genuine issues of material fact remain to be tried, and that the undisputed facts entitle the moving party to judgment as a matter of law. Tenn. R. Civ. P. 56; ***White v. Lawrence***, 975 S.W.2d 528 (Tenn. 1998); ***Byrd v. Hall***, 847 S.W.2d 208, 210 (Tenn. 1993).

In reviewing motions for summary judgment, courts are required to consider the evidence in the light most favorable to the non-moving party and draw all reasonable inferences in the non-movant's favor. ***White***, 975 S.W.2d at 529. Rule 56.05 provides that the non-moving party "must not rest upon the mere allegations or denials of his pleadings, but his response, by affidavit or otherwise must set forth specific facts showing that there is a genuine issue for trial . . .". Tenn. R. Civ. P. 56. When only one conclusion can be drawn from the undisputed facts, then the moving party is entitled to summary judgment as a matter of law. ***McCall v. Wilder***, 913 S.W.2d 150, 153 (Tenn. 1995).

The grant or denial of a motion for summary judgment by a trial court creates a question of law. Accordingly, appellate courts review the court's decision *de novo* without a presumption of correctness. ***Goodloe v. State***, 36 S.W.3d 62, 65 (Tenn. 2001); ***Mooney v. Sneed***, 30 S.W.3d 304, 306 (Tenn. 2000). The reviewing court must examine the record in the light most favorable to the non-moving party and determine if the moving party has met its burden under Tenn. R. Civ. P. 56. ***Hunter v. Brown***, 955 S.W.2d 49, 50-51 (Tenn. 1997); ***Mason v. Seaton***, 942 S.W.2d 470, 472 (Tenn. 1997).

VIII.

One thrust of the plaintiff's argument is that Rutledge, or his employee, supplied the answers to the questions propounded in the application, for which the plaintiff should not be held accountable. This issue arises in many, if not most, of the cases wherein Tenn. Code Ann. § 56-7-104 is of prominent effect. The corresponding thrust of the decisions concerned with the issue has consistently been that, about fraud, an applicant who signs an application for insurance without reading it, but certifies that he had read it and that his answers are true, is absolutely bound by his answers. ***De Ford v. National Life & Acci. Ins. Co.***, 185 S.W.2d 617 (Tenn. 1945). Consequently, the plaintiff is bound by his answers to the four (4) questions heretofore mentioned, which he answered at his own peril and must "suffer the consequences of his own negligence." ***Beasley v. Metropolitan Life Ins. Co***, 229 S.W.2d 146 (Tenn. 1950).

This Court has long recognized that even under circumstances where an insurance agent deliberately omits an insured's correct medical history on an application, which increases the risk of loss, there can be no recovery on the policy where the insured, failing to read the application, affirms the accuracy of the statements therein contained. ***Montgomery v. Reserve Life Ins. Co.***, 585 S.W.2d 620, 622 (Tenn. Ct. App. 1979) (citing ***Hardin v. Combined Ins. Co***, 528 S.W.2d 31 (Tenn. Ct. App. 1975) (citing ***De Ford*** and ***Beasley***)). *See also* ***Giles v. Allstate Ins. Co.,*** 871 S.W.2d 154 (Tenn. Ct. App. 1993) holding that insured's failure to read before signing application barred coverage, despite her allegations that she gave correct information to agent but that he filled application out incorrectly.

This Court has recognized that the failure to read a contract before signing it is gross negligence and prevents the person guilty of such negligence from claiming that the writing contained terms other than those the person believed it to contain. ***Solomon v. First American Nat'l Bank***, 774 S.W.2d 935, 943-44 (Tenn. Ct. App. 1989). The ***Solomon*** court also recognized that if parties have equal means of information so that with "ordinary prudence either may rely upon his own judgment, they are presumed to have done so and no cause of action for fraud arises."

In the case at Bar, it is indisputable that the plaintiff signed the enrollment form/application at issue, and that above his signature the form states: "I represent to the best of my knowledge and belief, that all statements and answers on this enrollment form are complete and true. The enrollment form and any amendments shall be the basis for the contact." He argues that any mistakes or misrepresentations contained on the form are the result of negligence on the part of

Rutledge and his employee, Debbie Alexander. However, at the time McPherson signed the completed enrollment form, it is indisputable that he neither looked at nor read the form before signing, and simply chose not to do so.

The plaintiff argues that the untrue answers were not material. We have held that a material misrepresentation by an insurance applicant exists when the misrepresentation is sufficient to deny the insurer of information it sought to discover and which it must have deemed necessary to an honest appraisal of insurability. ***Clingan v. Vulcan Life Ins. Co.***, 694 S.W.2d 327 (Tenn. Ct. App. 1985); ***Loyd v. Farmers Mut. Fire Ins. Co.***, 838 S.W.2d 542 (Tenn. Ct. App. 1992).

It is not necessary to show that a policy would not have been issued had the facts been known, but merely that the misrepresentation was of such importance that it naturally and reasonably influenced the judgment of the insurer in making the contract. *Id.;* ***Sine v. Tennessee Farmers Mut. Ins. Co.***, 861 S.W.2d 838 (Tenn. Ct. App. 1993). This simply means that the misrepresentation increased the risk of loss to the insurer. *Id.* But rescission is proper even where there is no intent to deceive. When a misrepresentation increases the risk of loss, the policy will be void regardless of whether there was intent to deceive. *See, e.g.,* ***Jefferson Standard Life Ins. Co. v. Webb***, 406 S.W.2d 738 (Tenn. Ct. App. 1966), wherein an insurance policy was set aside upon an insured's failure to set forth her child's true health conditions in her insurance application. The Court found no evidence that the insured intended to misrepresent her child's health, but the mere fact that the insured failed to provide important information increased the risk of loss to the insurer allowing the policy to be rescinded. And it is well settled that rescission is proper regardless of whether the misrepresentations are related to any actual loss under the policy. It does not matter that the insured's misrepresentations which increase the risk of loss to the insurer are unrelated to any actual loss under the policy. ***National Life & Acci. Ins. Co. v. American Trust Co.***, 68 S.W.2d 971 (Tenn. Ct. App. 1933). The fact that an insured makes material misrepresentations related to his medical condition is sufficient to increase the risk of loss to an insurer. *Id.* At 993-94. If the condition misrepresented by the insured on an application was required to be related to the actual loss, it would work an injustice upon the insurer because it would prevent the insurer from rescinding a contract when the misrepresentation itself actually induced the making of the contract and issuance of the policy. *Id.* At 994. The fact that the plaintiff misrepresented his health history with regard to prostatitis, skin cancer and depression, is sufficient basis to rescind the policy, even though the actual loss under the Fortis policy relates to back surgery and not to any of the conditions about which McPherson made the misrepresentations.

The issue of whether a misrepresentation by an insured naturally and reasonably influenced the judgment of the insurer in making the contract, and thereby increased the risk of loss, is a question of law. ***Womack v. Blue Cross & Blue Shield***, 593 S.W.2d 294 (Tenn. 1980). Under the undisputed facts of this case, the misrepresentation clearly increased the risk of loss. The plaintiff's failure to disclose his health conditions naturally and reasonably influenced Fortis' decision in issuing the policy. The failure to disclose three medical conditions (each involving different risks) is significant. Each of these conditions create greater risks to the insurer when evaluating a proposed insured's overall health. Moreover, each of these conditions (prostatitis, skin cancer, depression)

is addressed by a separate set of underwriting guidelines which indicated the relevance of questions relating to these conditions for the purpose of insurability. The underwriting guidelines for depression, for instance, reveal that Fortis would not have issued health insurance to McPherson if it had been aware of McPherson's history of depression. (*See* ***Clingan***, 694 S.W.2d at 330; and ***Loyd***, 838 S.W.2d at 545). The underwriting guidelines for prostatitis and melanoma also show the significance of these diseases to Fortis' decision making as it relates to insurance.

Information relating to all of these diseases naturally and reasonably influenced Fortis' decision regarding insurance to be issued to McPherson. Therefore, as a matter of law, misrepresentations regarding those matters increased Fortis' risk of loss, and activated Tenn. Code Ann. § 56-7-103.

IX.

The acts or omissions of John Rutledge, the insurance agent, do not excuse the plaintiff from misrepresentations in his application, or prohibit Fortis from rescinding coverage.

An insurer is entitled to rescind coverage for misrepresentations that increase its risk of loss regardless of whether the agent played a role in the misrepresentation. This Court had held that omissions by the insurance agent regarding the insured's medical history that increase the risk of loss to the insured will justify the rescission of coverage. There can be no recovery on the policy where the insured, failing to read the application, affirms the accuracy of the statements therein contained. ***Giles v. Allstate Ins. Co., Inc.***, 871 S.W.2d 154 (Tenn. Ct. App. 1993). In that case the insured's failure to read an application which contained a statement that the insured had read the application before signing and that the information on the application was true barred coverage, despite the allegation that the insured gave the correct information to the agent, but that the agent filled out the application incorrectly. *See also* ***Hardin v. Combined Ins. Co.***, 528 S.W.2d 31 (Tenn. Ct. App. 1975).

X.

The plaintiff argues that the principle of estoppel should be applied because Fortis determined that his back surgery was medically necessary, thus misdirecting him or lulling him into a false sense of security without which he would not have elected to proceed with the surgical procedure.

The insurance policy provides that Fortis is entitled to make a determination whether certain proposed medical treatment is medically necessary before the treatment is performed, a procedure called the Health Care Review process. The policy defines medically necessary treatment as:

> Treatment that we determine:

- is appropriate and consistent with the diagnosis and is in accordance with accepted United States medical practice and federal government guidelines;
- can reasonably be expected to contribute substantially to the improvement of a condition resulting from an illness or injury;
- is not for Experimental or Investigational Services;
- is provided in the least intense setting without adversely affecting the condition or the quality of medical care provided; and
- is not primarily for the convenience of you, your family, your Health Care Practitioner, or provider.

The policy also provides that even though Fortis may determine treatment to be medically necessary, any such treatment is subject to all of the terms and provisions of the policy:

> Health Care Review is not the same as "verification of benefits" and does not guarantee that benefits will be paid. Health Care Review addresses only the Medical Necessity and appropriateness of the care to be received. Payment of benefits is subject to all the terms, limits, and conditions of the plan.

The plaintiff and his health care providers requested that Fortis determine that the proposed back surgery was medically necessary, and sent the plaintiff a letter which recited the same statement set forth above, informing the plaintiff that a determination that the back surgery was medically necessary was not a guarantee of payment, and that the payment of any benefits was subject to all the terms and limits and conditions of the policy. Specifically, the letter stated:

> By certification of this hospital admission, and pursuant to the terms of your Fortis Health insurance policy, we are only confirming that this admission appears to be medically necessary based upon the information given to us. This letter is not a guarantee of payment or a guarantee of available benefits under your health insurance policy by Fortis Health. Payment of benefits are always subject to all terms, limitations, conditions and exclusions as described in your Fortis Health insurance policy. Any decision regarding the eligibility of these claims for payment will be made by Fortis Health at the time the claim is submitted.

XI.

The motion of Fortis included the ground that the elective surgery was recommended to correct a pre-existing back condition. The trial court granted the motion on this additional ground.

The plaintiff argues that this issue is contested and cannot be resolved by summary judgment, because at the time he submitted the application for coverage he had experienced no back problems.

Fortis argues that the plaintiff, in his complaint, alleged that he first sought medical treatment for his back pain on July 25, 2000, which was twenty-one days before the policy was issued. The policy provides that

> We will not pay benefits for covered charges incurred due to a pre-existing condition. . . .
>
> A pre-existing condition is an illness or injury and related complications not fully disclosed on the enrollment form, if during the 12-month period immediately prior to your effective date: You received medical treatment, consultation, or took prescription drugs for the condition. . . .

The plaintiff alleged, as stated, that he sought medical treatment on July 25, 2000. This pleading statement forecloses the issue. ***Petty v. Sloan***, 277 S.W.2d 355 (Tenn. 1955).

XII.

Finally, the plaintiff argues that the Tennessee Consumer Protection Act, Tenn. Code Ann. § 47-18-102, *et. seq.*, afford him a recovery under the peculiar facts of this case. It is true that the Act is applicable to insurance companies, ***Myint v. Allstate Ins. Co.***, 970 S.W.2d 920 (Tenn. 1998), and the plaintiff argues that the letter of December 5, 2000 "approving McPherson's surgery" when arranged against the letter subsequently posted rescinding coverage is evidence of a deceptive trade practice prohibited by the Act.

This argument misrepresents the manifest intent of the letter, as we have heretofore discussed.

The judgment is affirmed at the costs of the appellant.

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WILLIAM H. INMAN, SENIOR JUDGE